

King County Public Health Operational Master Plan

Role Definition White Paper
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Table of Contents

Caveat	2
Executive Summary	2
Introduction and Overview	7
▪ General Analytic Framework	7
▪ Distinguishing factors of a public health department's external environment	7
▪ A public health department's response to the external environment in terms of their roles, mission, and goals	7
Basic Role of a Public Health Agency - Distinguishing Factors of the External Environment	13
▪ Political and Operational Factors	13
▪ Demographic & Geographic Factors	18
▪ Size & Complexity	19
▪ Jurisdictional Complexity	20
▪ Geographic Characteristics	21
▪ Ports of Entry	22
▪ Risk	22
▪ Health Status	24
Basic Role of a Public Health Agency - Role, Mission and Goals in the Community	24
Conclusion	30
Appendix I – Public Health Frameworks	31
Appendix II – Interview Protocol	34
Appendix III – Population Characteristics	39
Appendix IV – Health Indicators	40
Appendix V – PHSKC Service Array	41
Appendix VI – Glossary	

Caveat

Please note: This White Paper should be viewed as a dynamic product reflecting information received to-date. There has been a continuous flow of documents and other information; it is likely that new information will continue to be provided during the life of this project. Moreover, interviews with the 5 metropolitan health departments have taken longer than planned, owing to variable availability of those being interviewed. It has not been possible in all cases to align our schedule with theirs. Accordingly, the reader should regard this paper as a draft that will be used to guide production of the policy framework and that will continue to evolve to inform policy recommendations in the next phase of the project. It should also be noted that while the RFP for the project specified information to be considered in the development of the White Papers, we are also considering other information that we deem important in development of the Operational Master Plan.

Role Definition Executive Summary

Distinguishing Features

- Wide variation exists among major metropolitan health departments (MMHD) in terms of their scope and complexity, yet still there are some commonalities:
 - MMHDs typically act more independently within their state-local public health system and have more complex day-to-day relationships with communities within their jurisdiction as the focal governmental public health agency.
 - Similar demographic and socioeconomic characteristics, major drivers of health status and health department focus, are present among MMHDs.
- King County is a demographically typical metro area, not unusual in most major respects to other metro areas and the five comparison MMHD jurisdictions.
 - Health inequities and its determinants are very important overarching challenges for all MMHDs
- Certain highlighted features about King County populations include:
 - Weekday population swells by an *additional* 400,000 workers.
 - Numerous vulnerable populations which are often outside the reach of regular health care provider and traditional public health and other emergency response systems need services.

- Annually approximately 32,000 individuals experience homelessness.
 - A rich and diverse culture and language base are prominent.
 - King County compares relatively favorably on overall socio-economic status (SES) characteristics with 5 comparison MMHDs and is somewhat in the middle on median household income, unemployment and poverty but has sharp disparities in the latter factors.
- Jurisdictional and governance oversight is complex in all MMHDs in the country, but almost three quarters have “county only” health departments.
 - A city-county governance structure is the least common arrangement, representing only about 10% of MMHDs.
 - PHSKC appears to have a relatively complex jurisdictional and governance arrangement.
- MMHDs have an important preparedness role to play in the case of natural or man-made disasters and deal with very complex emergency preparedness needs and systems.
 - PHSKC has the responsibility to connect King County's 19 hospitals, over 7,000 medical professionals, 27 community health centers, several specialty care facilities, and numerous primary care organizations to its public health preparedness network. The network of preparedness planning includes 30 fire departments, 8 HAZMAT teams, and 29 local law enforcement agencies.
- King County's geography has some unique features including urban, suburban and rural communities. Bordered to the east by the Cascade mountain range and to the west by the waters of Puget Sound, King County covers an area (2,126 sq. miles), slightly larger than the state of Delaware. Earthquakes, volcanic eruptions and tsunamis pose a risk for King county
- Seattle/King County is an international port of entry and trade with a high level of threat not only for acts of terrorism but also for infectious diseases such as SARS and Norwalk virus. Each year 1.1 million arriving airline passengers originate their flights from international destinations, and 100 cruise ships carry nearly 200,000 people who disembark.
 - Major cities such as Seattle are potential targets for terrorism.

Role, Mission, Goals and Services in the Community

- Statements of the role, mission and goals of MMHDs, including PHSKC, reflect remarkably similar philosophies, purposes and functions.
- Differences in the types and organization of services provided by MMHDs tend to reflect the unique characteristics of their jurisdictions, including traditions, history, and community values.
- The service array provided by MMHDs including PHSKC is aligned with the Ten Essential Service framework, and all essential services are addressed.
- PHSKC provides a highly comprehensive array of services. Over 90% of the public health services recorded in profiles collected by the National Association of County and City Health Officials (NACCHO) are provided within the PHSKC jurisdiction. These include all of the core communicable disease control services, environmental health, population based prevention, and basic health services.
- Functional comparisons of local public health agencies, as might be done for hospitals and other healthcare organizations, are challenging because local public health agencies (LPHA) including MMHDs are noted for their diversity in function and structure.
- Public health services can be made available in a community by: (a) direct provision of services by the LPHA or other public agency of the local government, (b) indirectly through funding by the LPHA of delegate agencies which deliver services, (c) indirectly through other agencies that are not funded by the LPHA but the LPHA regulates, coordinates or facilitates this third party service delivery. PHSKC employs all of these methods of service delivery
- MMHDs including PHSKC share similar jurisdiction characteristics but demonstrate considerable diversity in organizational characteristics, specific service configuration, governance, response to community needs, and relationship to the larger health care system. Typically this diversity is driven by the following factors:
 - Health related needs of those in the community
 - Prevailing beliefs about the appropriate role of a health department
 - Local tradition and history
 - Incremental decision making over time
 - Threats and crisis including unique risks
 - Opportunities, such as federal grant programs

- Politics and stakeholder advocacy
 - Current MMHD leadership
 - Division of responsibility between state and local governmental public health agencies.
- LPHAs (including MMHDs) are moving toward doing less service delivery directly and more through networks of delegate agencies and shared arrangements with other governmental agencies. PHSKC appears to be moving in this direction but at a slower pace than other MMHDs.
- Most of the five comparison MMHDs see legislative mandates as a reality that must be accommodated but not necessarily embraced by stringent conformity. PHSKC may find mandates as more influential in setting strategic direction than do other MMHDs
- Division of responsibility between the state and local public health agencies was not in itself seen as an important determinant of strategic direction, but PHSKC appears to share less of the public health burden with the state than do comparable metropolitan health departments (CMHDs).

Conclusions

We find that there are no major gaps in functions or services provided by PHSKC when compared to the profession's definition and expectations as well as to other MMHDs. Indeed, PHSKC is perhaps one of the most comprehensive metro-size health departments in the country. This comprehensiveness appears to derive from a confluence of factors including a strong tradition of governmental public health in the PHSKC region, a dedicated and highly competent public staff, seemingly extensive mandates, along with support and expectations from stakeholders in the authorizing environment.

This situation, however, may pose challenges to PHSKC in setting strategic direction. While PHSKC, like other CMHDs engages in strategic planning, a traditional strategic planning process alone may not be sufficient to overcome some of the external drivers for direction setting such that PHSKC can make strategic choices and set priorities. One consequence may be a service array that outstrips available resources.

Introduction and Overview

King County contracted with Milne & Associates, LLC, to assist in producing a Public Health Operational Master Plan for Public Health-Seattle & King County (PHSKC). One of the early deliverables in the project is the production of a report describing the purpose and role of a governmental public health agency in a major metropolitan health area and to describe how PHSKC carries out that role. Specifically, we were asked to address:

- Distinguishing factors of Major Metropolitan Health Departments (MMHD)
- The role, mission, and goals of MMHDs in their communities
- The basic role of a governmental public health agency in any community and the differences from the basic role and the role and purpose of an MMHD
- Compare several MMHDs and PHSKC on the distinguishing factors, roles, mission, and goals.

The complexity of large urban public health departments can be grasped by examining three perspectives that reveal factors which offer some insight into what these public health departments do and why they do it: (1) the general analytic framework of what separates a public health department from other health-related organizations, (2) the distinguishing factors of a public health department's external environment, and (3) a public health department's response to these factors in the community through established roles, mission, and goals.

General analytic framework

The first perspective is the broadest and addresses those considerations that separate a public health department from other health related organizations, such as a hospital or social service agency, whether governmental or not. These factors form a mental model or template which provides a broad framework for defining what constitutes a public health department, especially a large complex urban public health department. These factors describe the prototypical health department and are largely derived from the evolved tradition of the public health field and more recent thinking of national leadership organizations, both governmental and professional. Public health departments are expected to carry out certain specific activities as opposed to others. While these factors are not completely uniform or fixed, they do provide the broadest framework for establishing the identity of a public health department.

Distinguishing factors of a public health department's external environment

Public health departments, like most organizations, are influenced in a

strategic way by key features of their external environments. This second perspective, while related to the first, gets defined by the specific distinguishing features of the jurisdiction that might influence a large public health department's size, structure and service array.

A public health department's response to the external environment in terms of their roles, mission, and goals

The third perspective relates to the role, mission and goals of the public health department, which in essence is the strategic response that a public health department adopts in adapting to external demands. In adopting a specific response, a large urban public health department is likely to blend the distinguishing characteristics of its jurisdiction with some readily identifiable framework or model to establish its specific role and mission in the community.

In focusing on these three overarching perspectives and the factors which they reveal, this analysis attempts both to provide a descriptive overview of what public health departments are, for the purpose of providing context, as well as to highlight how PHSKC stands against these perspectives and in relation to peer major metropolitan health departments.

This report highlights distinguishing features of Major Metropolitan Health Departments (MMHDs) generally and more specifically those of Public Health-Seattle & King County (PHSKC). In some instances, more detailed comparisons are made with the jurisdictions served by the five comparable MMHDs (hereafter abbreviated as CMHDs) selected as comparables for the policy framework: Alameda County (CA), Columbus City (OH), Nashville-Davidson County (TN), Miami-Dade County (FL), and Nassau County (NY).

Like other MMHDs, PHSKC presents a range of interesting features which are of significant importance to various PHSKC stakeholders. To help create a policy focus for decision makers, we have singled out those elements of PHSKC which we believe are most relevant to this analysis.

- Of the 3,000 local public health agencies (LPHAs) in the United States, only 200 (or approximately 5%) are designated Metropolitan Health Departments (MHDs). While these agencies represent only a fraction of the total number of LPHAs in this country, individual MHDs are responsible for providing public health services to populations of 350,000 or more, and as a group provide services for nearly 60% of the U.S. population.
- Self-defined by their members as a “new and evolving classification,” the largest 25 MHDs in the country, or Major Metropolitan Health Departments (MMHDs), are further distinguished from other urban

health agencies on the basis of “population served,” and serve populations of nearly one million people or more. But MMHDs are hardly a homogenous group; there is wide variation in terms of their scope and complexity and as much as a tenfold difference in terms of population served. PHSKC is an MMHD serving 1.8 million people in King County.

Types of public health departments				
Category:	Local public health agencies	Metropolitan health departments	Major metropolitan health departments	Comparable metropolitan health departments*
Acronym:	LPHA	MHD	MMHD	CMHD
Number in the U.S.:	~3,000	200	25	5
Size of population served:	500 individuals to 9 million	350,000 to 9 million	1.2 million to 9 million	500,000 to 2.3 million
* The CMHD's in this report consist of the five following health departments: Alameda, CA; Columbus, OH; Davidson/Nashville, TN; Miami-Dade, FL; Nassau, NY.				

- MMHDs often have different relationships with their state health departments and communities than do other LPHAs. MMHDs frequently act more independently within their state-local public health system and have more complex day-to-day relationships with communities within their jurisdiction as the focal governmental public health authority.
- While the public health community has been wrestling for the past twenty years to develop a somewhat standard framework for determining the appropriate service configuration of a local public health department, only recently has a consensus started to emerge on what such a framework should include.
- It is difficult to make functional comparisons of local public health agencies, as might be done for health care organizations like hospitals. Local health departments are noted for their diversity in function and structure. The national public health leadership, including federal public health agencies and national professional bodies, have expressed concern about how this extreme diversity confounds efforts to define LPHA functions in a standardized way that might communicate the functions of public health to the broader public or permit functional comparison of public health agencies.

- The Ten Essential Public Health Services, formulated in 1994 by a workgroup convened by the U.S. Surgeon General, has emerged as the basic framework which the national public health leadership has used to define public health and the functions of public health systems at the state and local levels. The Ten Essential Services are cast in the language of public health professionals which is often not understandable to those who do not work in the field. Presented below are the Ten Essential Services along with a more common sense interpretation of what each means. (The description in italics are taken from Milne & Associates, LLC document “10 Essential Services in English”.)
1. Monitor health status to identify community health problems
 - *What’s going on in my community? How healthy are we?*
 2. Diagnose and investigate health problems and health hazards in the community
 - *Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?*
 3. Inform, educate and empower people about health issues
 - *How well do we keep all segments of our community informed about health issues?*
 4. Mobilize community partnerships to identify and solve health problems
 - *How well do we really get people engaged in local health issues?*
 5. Develop policies and plans that support health and ensure safety
 - *What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?*
 6. Enforce laws and regulations that protect health and ensure safety
 - *When we enforce health regulations are we technically competent, fair and effective?*
 6. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
 - *Are people in my community receiving the medical care they need?*

8. Assure a competent public health and personal health care workforce
 - *Do we have a competent public health staff? How can we be sure that our staff stays current?*
 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
 - *Are we doing any good? Are we doing things right? Are we doing the right things?*
 10. Research for new insights and innovative solutions to health problems
 - *Are we discovering and using new ways to get the job done?*
- The Ten Essential Services descriptions are at a generic level and, while they do serve to somewhat narrow the definition of public health, they are not sufficiently detailed as to *functionally* define the *specific* services that should be delivered by a LPHA. For example, there are several ways that any particular public health service can be made available in a community: (a) direct provision of services by the LPHA or other public agency of the local government, (b) indirect provision through funding by the LPHA of delegate agencies which deliver services, (c) indirect provision through other agencies that are not funded by the LPHA but the LPHA regulates, coordinates or facilitates this third party service delivery.
 - A more recent effort to define Local health departments in a more standardized functional way is underway, led by the National Association of County and City Health Officials (NACCHO) and based on the Ten Essential Services. The Operational Definition project (as it is called) is now into its second year and has recently released a report that attempts to more specifically define LPHA functions and 25 standards for how these functions might be conducted. NACCHO developed the operational definition of a local governmental public health agency to be "... the basis of future efforts to develop a shared understanding of what people in any community, regardless of size, can expect their governmental public health agency to provide at the local level..." The creation of this framework will allow for more direct comparison of functions and services among Local health departments. A more complete description of the Operational Definition elements is presented in Appendix I
 - In addition, while the Ten Essential Services are now generally accepted as a functional public health system framework, other frameworks have

been adopted by individual states. Noteworthy, Washington State has independently adopted *Proposed Standards for Public Health in Washington State* in 2000. The Washington State standards were developed to provide guidance in clear language on the basic capacity of every jurisdiction to offer public health protection in five areas:

- Protecting people from disease,
- Understanding health issues,
- Assuring a safe and health environment for people,
- Promoting health living, and
- Helping people get the services they need.

The Washington State Public Health Improvement Plan from 1993 influenced the development of the Ten Essential Services and the Ten Essential Services influenced Washington State's most recent efforts. The Washington State standards appear to be closer in purpose to the Operational Definition – to facilitate implementation and action rather than simply to define functions. Washington State's efforts in this area are grounded in state legislation; a fuller description is provided in Appendix I.

- Functional diversity is somewhat narrowed when LPHAs are clustered by jurisdiction size. As might be expected, the largest agencies have more in common with each other than they do with smaller LPHAs. For example, while the Ten Essential Services are recommended by the Institute of Medicine (IOM) as a common framework for local public health departments of all sizes, the largest public health departments are more likely to offer a greater number and a greater intensity of the Ten Essential Services in their jurisdictions than do smaller public health departments. This distinction has proven to be functionally useful; NACCHO has formally organized its membership into three groupings roughly corresponding to size. The Metro Forum, to which PHSKC belongs, is comprised of the largest LPHAs that are usually associated with a metropolitan area. While these LPHAs share similar jurisdiction characteristics including population size and diversity, health status conditions, community role, basic functions, and finance and management challenges, they still exhibit considerable diversity in organizational characteristics, specific service configuration, governance, response to community needs, and relationship to the larger health care system.

I. Basic Role of a Public Health Agency - Distinguishing Factors of the External Environment

Political and Operational Factors

- An examination of most large health departments across the nation suggests the ten factors below play an influential role in determining specific LPHA roles, missions, and functions. These factors were derived from the experience of the Milne & Associates team in the areas of public health department functions, structure and financing. The relevance of these factors was validated through the interviews conducted with executive leadership and senior management of the five comparable health departments (CMHDs) and is presented in Appendix II.
 - **Community need** as determined by epidemiologic analysis of the overall demographic characteristics and health status conditions
 - **Prevailing beliefs** about the appropriate function of a LPHA, especially in relationship to the larger health care system
 - **Local tradition** and history
 - **Incremental decision making** over time that tends to layer-on functions
 - **Threats** and crisis including unique risks
 - **Opportunities**, such as funding opportunities (e.g. federal grant programs such as Model Cities and Ryan White)
 - **Politics** and stakeholder advocacy including elected official and community expectations
 - **Current LPHA leadership** which can set overall direction, create emphasis and drive change
 - **Jurisdictional division of responsibility** between the state and local public health agencies
 - **Statutory authority** from which the local health department derives its powers.
- LPHAs as a class of public agencies are moving toward doing less service delivery directly and more through networks of delegate agencies in following the public management trends of doing more "steering" and less "rowing", a concept advanced in the "reinventing government" movement (Osborn and Gabler), more recently termed "government by network". This approach is formally taking hold in public health through the concept of the public health system -- the network of organizations and agencies in a community that actively contributes to improving the health of the community. The public health system has played a more prominent role in local public service delivery since the

most recent IOM Report, "The Future of the Public's Health" (2002) and is being advanced by the Centers for Disease Control & Prevention (CDC). The principal recommendation in this report and advanced by the CDC suggest that the focus of public health action at the local level should shift from the public health agency to the public health system which includes:

- Community based organizations and the community at large
- The Health care delivery system
- Employers and business
- The media
- Academia
- The governmental public health infrastructure

Under this construct, local health departments become key enablers and form the core of the public health system but recognize that the health of a community depends on the participation and action of a variety of players beyond health departments.

- Used in tandem, the Ten Essential Services and a comparison of PHSKC to comparable MHDs/CMHDs, provides both a general and specific analytic framework for the examination of PHSKC's role and functions.

While PHSKC and all CMHDs reported in their interviews that each of the influential factors listed above played a policy role for their public health department, there was some variation in the degree of influence exerted by each factor and the response of each public health department.

- **Community need**, as defined by population demographics and health status conditions, was rated as being a very important driver of strategic direction and LPHA functions for PHSKC and four of the five MMHDs. Each was able to identify specific population demographic changes and community health status conditions for which their health department was specifically tracking and responding. Three CMHDs had developed sophisticated mechanisms for obtaining and analyzing data on community needs. Even the one CMHD that rated community need overall as a lower priority driver was able to identify several specific community conditions of concern to the CMHD and did so in making the point that responding to community needs was very important but depended on funding. PHSKC assesses community health, system capacities, community assets and values to carry out strategic priority setting. The highly diverse demographics of its jurisdiction present both opportunities and challenges.

- Three of five CMHDs rated **prevailing beliefs** about the appropriate function of a LPHA as a very important driver but several noted that beliefs did not always fit the reality. The public is more concerned with *medical care services* than with a broad vision of *public health* and tends to mischaracterize the CMHD's primary role as a health services provider for the poor. One CMHD was actively trying to counter that through "re-branding." The one CMHD that rated prevailing community beliefs as not important saw itself as being somewhat insulated from overall public pressure largely due to solid support among specific community stakeholders. PHSKC rated this factor as neither important nor unimportant.
- The role of **local tradition** and history as a driver of strategic direction varied among CMHDs. Two noted that it was very important, with others seeing it being rather neutral. There was a general recognition that history provides a sense of tradition that can be drawn upon and used to set the stage for current and future action. However, there was also awareness that tradition can "bog you down" and be used to resist needed change. PHSKC rated this factor as rather neutral, noting that tradition can hold the public health department back but did not stop it from moving forward.
- All of the CMHDs and PHSKC had much to say about mandates as a policy driver and four of five CMHDs rated legislative mandates as important or very important. Most saw legislative mandates as a reality that must be accommodated but not necessarily embraced. Only one CMHD saw legislative mandates as fully determining strategic direction and functions ("95% of our programs are mandated by the state"). Other CMHDs looked for ways to lessen the burden of mandates, especially unfunded mandates, through:
 - negotiation with the mandate source,
 - absorbing mandates into existing operations,
 - using the agency strategic plan to determine how to address the mandate,
 - advocacy for either commensurate funding or removal of the mandate by working through the board of health or community stakeholders.

Grants and contracts were seen as a more manageable form of mandate because there was greater choice on the part of the CMHDs regarding how or even if a grant was to be pursued or a contract entered into. Three of the five CMHDs mentioned specifically the federal bioterrorism preparedness grant administered by states was particularly burdensome due to overly rigid requirements, intrusive

monitoring, or insufficient funding from the state. PHSKC has benefited from the federal dollars available for public health disaster preparedness.

PHSKC rated mandates as very important, noting that mandates define much of what it does. PHSKC seems to find mandates of such significance that it has set up a compliance office, a response not reported by other MMHDs.

- Four CMHDs acknowledged that **incremental decision making** over time can layer-on functions leading to “mission creep,” and for that reason rated it important to very important as a factor in strategic direction. Drivers of incrementalism mentioned by CMHDs included union contracts, evolving grant-funded programs and successive mandates. The overall view of this factor was negative but one CMHD noted that making incremental changes can be useful in helping staff see how a larger vision can be achieved. Only one CMHD rated this factor as largely unimportant. PHSKC rated this factor as neither important nor unimportant, noting that everything is reviewed each year so functions are less likely to get layered on.
- **Threats and crises** affecting the jurisdiction were seen as important to all five CMHDs, but only one rated it very important. This is surprising given the strong recent national emphasis on public health emergency preparedness. One possible reason offered by four of the five was a keen awareness of potential crisis coupled with effectiveness in integrating emergency preparedness into their routine operations so that they seldom had to operate in a crisis mode. PHSKC rated this factor to be very important, noting the complexity involved in preparedness planning.
- All CMHDs, and PHSKC, rated **funding** opportunities as important to very important determinants of strategic direction. All but one also noted that, important as new resources are, grants are only pursued for which there is a strategic fit, at least in the long run.
- **Politics and stakeholder advocacy** was a driver of strategic direction acknowledged by all five CMHDs, but only one CMHD rated this as very important due to community stakeholder interests, not from elected officials. The five CMHDs appear to be striking a balance of maintaining the interest of elected officials while managing their demands. Several strategies for dealing with elected officials were offered:
 - Regular meetings with elected officials
 - Including elected officials in the strategic plan development

- Using the board of health as a buffer between elected officials and the public health department
- Using community based organizations to influence elected officials

One CMHD noted that there was little community or elected official interest in the public health department, possibly because that same CMHD also reported that state mandates largely determine the public health department's functions and programs. Another CMHD, touching on the same theme, noted that there was little elected official "interference" because the small level of local funding seemingly made the effort of little worth.

PHSKC rated this factor as important, emphasizing that the views of the many elected officials served by PHSKC were very influential, perhaps more so than may be the case with other CMHDS that do not serve as many jurisdictions. PHSKC did not see the role of politics and advocacy as a negative influence, noting that the dynamic between elected officials' influence and community advocacy often helps identify acceptable middle ground.

- **Leadership** within the local health department was seen as important or very important to strategic direction by PHSKC and four of the five MMHDS. Leadership was exercised usually through the strategic plan and involved a top level management team in routine decision making. Leadership was seen as important for high level organizational purposes such as direction setting, establishing the public health department's agenda, driving change, developing policy, and establishing management tone and organizational culture. At least one CMHD noted that resources are dedicated to internal leadership development. The one CMHD that did not see leadership as important was the same one that reported its direction as being largely set by state mandates. This CMHD also reported that many of its senior managers were either unionized or were long-standing employees, not selected or promoted by the health officer. PHSKC noted that having too much emphasis on leadership or too high a profile can make leadership a target for criticism.
- **Jurisdictional division of responsibility** between the state and local public health agencies was not in itself seen as an important determinant of strategic direction. Only one CMHD rated this as very important -- the same CMHD which reported the determining role of state mandates. Three CMHDS noted that they are independent of the state and can set their own direction. The fifth CMHDS is part of a

centralized state-local public health system. Four CMHDs noted areas of friction with the state including: a lack of state leadership, the state's inclination to take a "one size fits all" approach in relation to LPHAs, rigid "silos" in the state health agencies' organizational structure, resistance to new ideas, and an unfair sharing of state-wide public health resources. PHSKC was similar to other CMHDs in rating this factor, noting that the relationship with the state was good at present but has not always been that way.

- Having **statutory authority** for action was viewed as very important by PHSKC and all but one CMHD. But several noted that having broad authority was more useful than specific authority as it provided flexibility to address concerns not specifically covered in the statutes.
- Finally, an overarching issue discussed by all CMHDs across these determinants was the importance of **health inequities** within their population. Indeed, this is a challenge faced by all CMHDs in the country. This issue will be addressed in greater detail in the White Paper on Health Environment.

Demographic and Geographic Factors

Several features of the jurisdiction that have an influence on a MMHD's role, mission and service configuration are examined below. These include: size and complexity of the population, jurisdictional complexity, geographic and topological characteristics, impact of ports-of-entry, risks and potential threats, and overall population health status characteristics. Focusing public health efforts at a population level is one of the principles of public health, and a number of demographic characteristics influence population health status. The age structure of the population influences both health status and health services utilization. Older populations tend to have poorer health status and have higher health services utilization rates. Income and socio-economic status is another important characteristic and has been found to be the single best predictor of health and illness. Not surprisingly, lower income populations tend to have poorer health status and lack access to health care services due to having lower levels of health insurance coverage. Poverty also is a major contributing factor in homelessness, chronic illness, and many communicable diseases. Ethnic composition is important because health behaviors are strongly influenced by cultural beliefs; cultural competency is necessary for health care providers and health educators to effectively communicate with individuals and the community. Key public health demographic characteristics such as fertility and birth rates vary by income and ethnicity.

Unfortunately, ethnicity and socio-economic status can interact negatively and result in disparities in health status that affects the several larger minority groups including African Americans, Hispanics and Native Americans.

Size and complexity of the population

- The 25 MMHDs in the U.S. are responsible for providing public health services to nearly 60 million people. The smallest MMHD, Contra Costa County (CA) Health Department, serves approximately one million people, while the Los Angeles County Health Department serves a population of nearly 10 million people. Most MMHDs serve populations in the 1-3 million range.
- Demographic and socioeconomic characteristics -- major drivers of health status and health department focus -- vary widely within the counties served by MMHDs.
 - *US population* grew by 13% in last census decade with greater growth noted among non-white, non-Hispanic racial and ethnic populations, a trend which is generally mirrored in the jurisdictions served by MMHD.
 - *Ethnic diversity* is usually greater in metro areas but can vary greatly. Minority populations (non-white) among the CMHDs range from over 80% in Miami-Dade County to 17% in Allegheny County, Pennsylvania.
 - *Age composition* also varies. According to 2000 Census figures, population under age 18 ranges from 16.8 % in New York County to 32.3% in San Bernardino County. At the other end of the age scale, persons over age 65 ranges from 7.4% in Harris County, Texas to 23.2% in Palm Beach County, Florida.
 - Characteristics of socio-economic status (SES), also an important correlate of health status, show significant variation among MMHDs. Poverty (2004) ranges from just over 5% of the population in Nassau County, New York to 25% in Philadelphia County.
- PHSKC is the 10th largest MMHD in the nation, serving nearly 1.8 million people and a third of the state's population. Additional distinguishing features of the King County population include:

- The population swells each weekday by an *additional* 400,000 workers.
- The existence of numerous vulnerable populations of significant scale, including people with disabilities, people with serious mental illnesses, minority groups, non-English speakers, children, and frail elderly. Many do not have a regular health care provider and are beyond the reach of traditional public health and other emergency response systems.
- A homeless population on any given night of about 8,000 individuals in shelters or sleeping outside; on an annual basis approximately 32,000 individuals experience homelessness.
- A diverse language base, in which as many as 80-100 languages are spoken in schools and at least 10 language groups require regular translation and interpreter services in public health clinics alone.
- King County is a demographically typical metro area (please elaborate), not unusual in most major respects to other metro areas and five CMHD jurisdictions (see Appendix III).
- King County compares relatively favorably on characteristics of socio-economic status with 5 CMHDs (see Appendix III): it is somewhat in the middle on median household income, unemployment and poverty.

Jurisdictional complexity

- Jurisdictional complexity can influence public health organization and service delivery by complicating the ability of jurisdictions to come together and make collective decisions that affect the community's health. Decisions regarding public health mission, program focus and funding are complicated when multiple decision making bodies are involved.
- Depending on the model of governance, MMHDs may be responsible for serving city-only, county-only or city-county combined populations.
 - Nearly 75% of MMHDs represent single political jurisdictions in the form of "county only" health departments.
 - A city-county governance structure, as is the case of PHSKC, is the least common arrangement, representing about 15% of all local

public health agencies nationally. Only about 10% of MMHDs fall into this category.

- The number of municipalities served by MMHDs ranges from 1 to 150. PHSKC is responsible for providing public health services to 39 municipalities, a relatively high number compared to CMHDS.

Geographic characteristics

- Geographic characteristics that may influence a MMHD's role and service configuration include proximity to state, multi-state or international borders, topographical complications that challenge transportation (e.g. vast distance or barriers such as mountains for rivers), climate conditions, coastal location, and geological factors (active volcanoes, geologic faults).
- The twenty-five MMHDs are concentrated in ten states: California (9), Florida (3), Texas (3), New York (2), Michigan (2), Pennsylvania (2), Arizona (1), Illinois (1), Nevada (1) and Washington (1). With the exception of four interior health departments, the remaining MMHDs are located along the periphery of the U.S. border and either directly, or indirectly, shares a border with one of the following significant bodies of water - the Great Lakes, the Atlantic Ocean, the Gulf of Mexico or the Pacific Ocean. The majority of these counties also meet the criteria for designation as "coastal counties" by the National Association of Counties (NACO).
- Counties containing MMHD vary in total area from 135 square miles in Philadelphia County to 20,062 square miles for San Bernardino County, and in their proximity to shared political borders. Only San Bernardino and Riverside counties in California border another state, and none of the MMHDs share multi-state borders. San Diego County Health Department is the only MMHD whose jurisdiction is directly contiguous with an international border (Mexico).
- King County's geographical variety includes 39 cities and suburban cities, and rural communities in the eastern portion of the county. Bordered to the east by the Cascade mountain range and to the west by the waters of Puget Sound, King County covers an area (2,126 sq. miles) slightly larger than the state of Delaware.

Ports of entry

- Ports of entry have been of traditional concern to public health officials as a points of entry for disease. The public health practice of quarantine started with a an effort to prevent disease from embarking with those sailing into ancient ports. And today, with global travel comes the risk that the emerging infection in some distant country is just a plane flight away from becoming rooted in the United States.
- The definition of ports of entry has broadened in this age of globalism beyond the typical boarder points of national entry and exit. Ports of entry now include interior international airports, major points along interstate highways, and communities with large concentration of immigrant populations.
- As MMHDs are located in large metropolitan areas, all have at least one international airport either within their home county (this is true for the majority of MMHDs) or in a neighboring county, and in some cases, multiple airports serve MMHD counties. Given the distribution of the MMHDs along the United States periphery as noted above, most of these health departments are located in counties with access to major sea or lake ports, or border counties with immediate such access.
- Seattle/King County is an international port of entry with a high level of threat, not only for acts of terrorism but also for infectious diseases such as SARS and Norwalk virus. Each year nearly 30 million passengers travel through SeaTac Airport with over 1.1 million of these originating from international destinations. During the five month summer season this year, over 100 cruise ships carrying nearly 200,000 passengers disembark in King County.
- Raising additional security concerns, King County is reachable also as a major transcontinental transportation hub for Amtrak, Burlington Northern, and Union Pacific railways, and Seattle is homeport for the U.S. North Pacific fishing fleet and a U.S. Naval base.

Risk

- While the U.S. has become sensitized to risks posed by acts of terrorism, emerging infectious disease and natural disasters, public health risks include these and other sources that while not as prominent in the public mind, do pose potential threats to the health and safety of an

urban population. These include reemerging infections such as drug resistant TB, chemical spills, toxic substance releases, and population characteristics, including density that create an elevated exposure potential or predisposition.

- It is commonly assumed that major cities are potential targets for terrorism; those with special risk might be those with key governmental functions (e.g. Washington D.C., other state capitols); or with symbolic factors (e.g. Statue of Liberty, Wall St., tallest buildings, major landmarks like bridges (Golden Gate) or features (Space Needle).
- Cities that on a somewhat regular basis are exposed to significant weather, tide or other meteorological issues are at greater risk. Seattle's position at the base of an old and major volcanic, Mt. Rainier or its geographic proximity to a more recent volcanic threat, Mt. St. Helens is one such example. More significantly, Seattle lies on a major geologic fault line where earth quakes have been a real threat.
- Given their central role and responsibility for significant portions of a state's population (as much as one-half, in some cases), MMHDs have an important preparedness role to play in the case of natural or man-made disasters and must be able to deal with more complex emergency preparedness needs and systems. MMHDs have the direct responsibility for planning and coordinating with hospitals, community health centers, multiple first responders, community based organizations, and ethnically and linguistically diverse populations to establish preparedness capacity. The extent of risk posed by any given event may be complicated by the diversity of their populations and disparities in communications and other essential infrastructure necessary to mount an effective response.
- PHSKC has the responsibility to connect King County's 19 hospitals, over 7,000 medical professionals, 27 community health centers, several specialty care facilities, and numerous primary care organizations to its public health preparedness network. Similarly, first response organizations are included in this network of preparedness planning--30 fire departments that provide Basic or Advanced Life Support response throughout the county, 8 HAZMAT teams, and 29 local law enforcement agencies that have jurisdictional authority for response to criminal acts, including acts of bioterrorism.

Health status

- Public health authorities use a variety of indicators to profile a population's collective level of health (health status). These include indicators of morbidity (death rates), mortality (the presence of disease), disability, health care utilization, behavioral risk factors (e.g. smoking), and components of population change (e.g. birth and mortality rates).
- According to the Big Cities Health Inventory (2003), which provides a ranking of the nation's 47 largest cities (those with populations \geq 350,000) across 20 health indicators, the city of Seattle ranks relatively favorably vis-à-vis its peers: it performs in the upper quartile of big cities for nearly half of the 18 indicators for which data is available, and is in the middle quartiles for the remaining indicators. Seattle receives its lowest ranking (15) for its suicide rate.
- Select health indicators for Seattle and the major cities served by the five CMHDs are detailed in Appendix IV. Seattle performs the best in three indicators (heart disease mortality, homicide, and infant mortality), and is among the top three in the remaining indicators (overall mortality, cancer mortality, and motor vehicle mortality).

Basic Role of a Public Health Agency - Role, Mission and Goals in the Community

- Nearly all CMHDs have mission statements and strategic goals that express at the highest levels the role and mission of the health department in the larger community. This is the case for PHSKC and for all the five CMHDs examined here. While these statements of purpose and strategic intent may use different language and be formatted in different ways, they largely reflect similar philosophies, purposes and functions. Their differences tend to be more a reflection of the unique characteristics of their jurisdictions, including traditions, history, and community values. The role and mission of a MMHD is most concretely expressed in the services that are provided and how these are organized.
- The configuration of public health services provided within a jurisdiction can be examined from two perspectives. First is the service array itself, regarding type and number of services, and second is how the services are organized or delivered. While there is no standard taxonomy of

public health services, NACCHO has developed a service listing of 75 services, grouped in 11 categories that are reported on by public health services across the nation in NACCHO's local health department profile survey. While the Ten Essential Services (and the Operational Definition) prescribe what a public health department should do, the NACCHO profile survey attempts to gather information on what public health agencies actually do. The NACCHO profile survey also provides some insight into how services are offered in a jurisdiction, presenting five possibilities:

- Performed directly by the local public health agency (LPHA)
- Contracted by the LPHA
- Provided by a state agency
- Provides by another local government agency
- Done by some other agency in the community

This service taxonomy will be used for this analysis, and the results for PHSKC are presented in Appendix V.

- As an MMHD, PHSKC provides a highly comprehensive array of services. Over 90% of the NACCHO profile public health services displayed in Appendix V are provided within the PHSKC jurisdiction. These include all of the core communicable disease control services, environmental health, population based prevention, and basic health services. A few regulatory related services regarding mobile homes, campgrounds/RVs, cosmetology, food processing are not offered in the jurisdiction, most likely because they are of very low relevance to this jurisdiction. This is comparable to the other CMHD for which we have data
- Over 88% of public health services provided in King County are provided either directly or indirectly by PHSKC; however, agencies other than PHSKC play a major role in the delivery of public health services as well, as only 21% of all services provided are delivered by PHSKC alone. About one quarter of all services provided are done so either by contract to PHSKC, or by a state agency or another local governmental agency. Another 31% are provided independently by other agencies in the community. (Appendix V) PHSKC directly provides or funds a comparatively high number of public health services compared to other CMHDs, and PHSKC directly provided or contracts with others for delivery of the highest number of services compared to other CMHDs
- PHSKC contracts for nearly 25% of public health services available. For each of the contracted services, no contractor is the sole provider of that service and, in fact, PHSKC provides those services directly as well.

(Appendix V) This is not an unusual situation compared to the other CMHDs.

- In King County, the State is most likely to provide regulatory and environmental health services. Other local governmental agencies provide mental/ behavioral health services, some population prevention services, a few regulatory and environmental health services, and most prominently other related public health services including animal control/veterinary service, occupational safety, laboratory services, hazardous waste disposal, school health and medical insurance outreach and enrollment. Non governmental community agencies share much of the core public health and clinical services. But PHSKC, compared with the CMHDs, was among the lowest for the number of public health services provided by the state, providing only about 50% of the number of services provided in the jurisdictions of the two CMHDs where the state played the greatest role.
- Contracted services include mental/behavioral health and several regulatory/environmental health related service which are provided by a state agency. While services in PHSKC are delivered through a wide collection of agencies other than PHSKC, PHSKC is directly involved (either by direct provision or by contract) in nearly 80 public health functions within the jurisdiction, a far higher number than other CMHDs which range from 64 to 43 services. Compared to the CMHDs, other entities including the state, other local government agencies, and other non-contracted organizations are more involved in providing services in the jurisdiction than in Seattle/King County.
- One way to gauge the adequacy of an MMHDs' service array is to examine the NACCHO service array against the Ten Essential Services framework which has been used by PHSKC and all five comparable MMHDs. In addition to examining the actual services provided, this assessment considered the resources available to PHSKC, as reported by PHSKC in NACCHO's 2006 Profile survey, other documents and interview information.
 1. Monitor health status to identify community health problems
 - PHSKC services include epidemiology for communicable/infectious disease, chronic disease, injury, and environmental health performed by 20 staff epidemiologists and other staff
 - The CMHD also perform these services, but appear to share the responsibilities with the state health department

or other local governmental agencies more than does PHSKC.

2. Diagnose and investigate health problems and health hazards in the community
 - PHSKC services include adult and child immunizations, screening for HIV/AIDS, sexually transmitted diseases, TB, cancer, cardiovascular disease, hypertension, pediatric blood lead, animal control, occupational health, and laboratory. The CMHDs all provide these services in a similar manner to PHSKC, both as a direct provider and in conjunction with other agencies in the community and at the state level
 - PHSKC and CMHDs all provide, directly or indirectly, treatment for HIV/AIDS, sexually transmitted diseases and TB.
 - PHSKC along with all CMHDs has developed or made updates in an emergency preparedness plan, reviewed relevant legal authorities, participated in exercises/drills, participated in an actual public health emergency
3. Inform, educate and empower people about health issues
 - PHSKC assures or provides population based primary prevention services in injury, unintended pregnancy, obesity, violence, tobacco use, substance abuse and mental illness, and has dedicated staff in health education and nutrition
 - Other CMHDs also provide or assure these services in largely similar arrangements to that of PHSKC
4. Mobilize community partnerships to identify and solve health problems
 - PHSKC has completed a recent community health assessment and health plan and reports significant involvement of other entities in the community in public health service delivery
 - Other CMHDs also have sophisticated health assessment and planning functions which involve members of the public. One has developed an extensive community planning and participation manual. Two others have piloted a national community strategic planning process, Mobilizing Action through Planning and Partnerships (MAPP) which features extensive community participation.

5. Develop policies and plans that support health and ensure safety
 - PHSKC routinely provides reports on the health of the Seattle-King County area, serves as a resource to governing bodies and policy makers, advocates for policies that lessen health disparities and improve health, and engages in organizational strategic planning.
 - To one degree or another, other CMHDs develop policies and plans, issue reports on health needs and attempt to influence policy. Nearly all have organizational strategic plans.
6. Enforce laws and regulations that protect health and ensure safety
 - Regulation, inspection and/or licensing activities for: solid waste disposal, septic tank installation, schools/day care, swimming pools, tobacco control, lead/housing inspection, drinking water, food protection, and health facilities are provided within the PHSKC jurisdiction by either PHSKC or other governmental agencies
 - Other environmental health activities including: indoor air quality, vector control, land use planning, ground water protection and noise pollution are also provided by PHSKC
 - The CMHDs examined also appear to provide a comparable range of inspection and regulatory functions with some differences in the involvement of other governmental agencies (e.g. state vs. local).
 - Based on the NACCHO Profile survey data (Appendix V), for regulatory and environmental health activities, other CMHDs appear to share responsibility more with other local governmental agencies than does PHSKC. Of the 27 regulatory and environmental health related services in the NACCHO profile survey, PHSKC is among the lowest in having services offered in the jurisdiction provided by the state or other local agencies.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
 - PHSKC services include comprehensive primary care (the most basic medical service), oral health, emergency medical services, school based clinics, correctional health and outreach/enrollment for medical insurance

- Other CMHDs also provide or assure a similar range of services but seem to rely more on an indirect role in working through other agencies than does PHSKC. PHSKC seems to be unique among the five CMHDs in directly providing obstetrical and primary care
 - While CMHDs in general are involved in connecting those in need to behavioral health services, very few actually provide mental health services, relying instead on networks of community mental health agencies. Only one comparable CMHD was a direct mental health provider
8. Assure a competent public health and personal health care workforce
- PHSKC conducts training using a broad variety of training sources and formats with specific training for evidence-based health promotion, applied epidemiology, core competencies for public health workers and public health informatics. PHSKC has assessed staff competencies and provided training in emergency preparedness.
 - All other CMHDs report involvement in training to one degree or another, but PHSKC appears to have made a greater investment in this area
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- PHSKC routinely conducts internal program evaluation activities, evaluates the effectiveness of public health services provided in the jurisdiction and encourages partner agencies to engage in program evaluation
 - Other CMHDs report evaluation activities which range from formal department wide initiative to more sporadic program focused evaluation. One CMHD has formed a unit with specific responsibility for evaluation.
10. Research for new insights and innovative solutions to health problems
- PHSKC has relationships with area universities and academic public health programs and participates in clinical trials where appropriate
 - Most CMHDs report relationships with academia which vary in depth and comprehensiveness. PHSKC may have a relatively greater and more formalized research involvement than do the CMHDs.

Conclusion

Based on the available information, the following initial conclusions can be made and implications drawn from the analysis. These conclusions are provisional and subject to further testing and refinement as additional work on the Operational Master Plan proceeds.

- While all large health departments have unique characteristics, from a demographic and geographic perspective, PHSKC appears to be typical, with few features that would overly influence its role, mission and service array, compared to other large metropolitan health departments.
- PHSKC appears to have a relatively complex jurisdictional arrangement to serve and to provide some accountability to a large number of jurisdictions and oversight bodies. This arrangement may complicate PHSKC's ability to make strategic decisions, as many stakeholders must be consulted and satisfied. PHSKC leadership rated the influence of politics and stakeholder advocacy as very important as a driver of strategic direction.
- For PHSKC, mandates or the perception of mandates may play a highly influential role in setting strategic direction. Mandates can come from actual legislative or contract requirements, but also appear in the form of stakeholder expectations, particularly from elected officials or strong interest group pressure. Several CMHDs seemed to more critically examine or challenge what appeared on the surface to be mandates. (This issue will be explored in greater depth in both the policy and funding papers.)
- A pattern that clearly emerges in examining the PHSKC service array against the Ten Essential Services framework is that all essential services are addressed within the PHSKC jurisdiction in a very comprehensive manner. Using this framework, from an overall perspective, PHSKC looks much like other CMHDs, as those examined appeared to provide or assure all Ten Essential Services.
- For some services, particularly treatment-related services, PHSKC may be more inclined to directly provide the service as opposed to providing the service indirectly through other agencies.
- The division of responsibility for assuring some services may be more concentrated within the health department in the PHSKC jurisdiction compared to other CMHDs, which seem to share the responsibility more widely with other agencies of local government or with the state.

From this analysis we find that there are no major gaps in functions or services provided by PHSKC when compared to the profession's definition and expectations as well as to the services provided by other MMHDs.

Indeed, PHSKC is perhaps one of the most comprehensive metro-size health departments in the country. This comprehensiveness appears to derive from a confluence of factors, including a strong tradition of governmental public health in the PHSKC region, a dedicated and highly competent public health staff, seemingly extensive mandates, along with support and expectations from stakeholders in the authorizing environment. This situation may pose challenges to PHSKC in setting strategic direction. While PHSKC, like other CMHDs, engages in strategic planning, a traditional strategic planning process alone may not be sufficient to overcome some of the external drivers for direction setting noted above, to the degree that PHSKC can make strategic choices and set priorities. One consequence may be a service array that outstrips available resources. Implications include streamlining decision making to concentrate policy authority in a single oversight body, developing a more tailored strategic planning process, assuming a more aggressive posture toward mandates and burden sharing, and strengthening the role of the PHSKC executive leadership to help clarify and drive strategic direction.

As we move into Phase II of the OMP, we expect to more closely study and analyze the department's array of services, specifically focusing on how the department is best structured to provide these services and on opportunities for greater effectiveness and efficiency in service delivery well into the future.

Appendix I – Other Public Health Frameworks

The Operational Definition of a Local Health Department. The summary below is taken from a brochure produced by the National Association of County and City Health Officials which describes the Operational Definition and proposed standards that are not under review. This brochure is available at the following web site:
<http://www.naccho.org/topics/infrastructure/documents/OperationalDefinitionBrochure.pdf>

All local health departments exist for the common good and are responsible for demonstrating strong leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that

- Improve health and well-being;
- Prevent illness, disease, injury, and premature death; and
- Eliminate health disparities.

A functional local health department:

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them.
- Investigates health problems and health threats.
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors.
- Leads planning and response activities for public health emergencies.
- Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health significance (e.g., natural disasters).
- Implements health promotion programs.
- Engages the community to address public health issues.
- Develops partnerships with public and private healthcare providers and institutions, community-based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems.
- Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner.
- Addresses health disparities.

- Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies.
- Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community.
- Provides its expertise to others who treat or address issues of public health significance.
- Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate.
- Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions.
- Facilitates research efforts, when approached by researchers, that benefit the community.
- Uses and contributes to the evidence base of public health.
- Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectations.

Washington State Standards for Public Health Washington State law mandates the establishment of basic standards for public health as a part of the biennial Public Health Improvement Plan, a process designed to strengthen the public health system in order to improve the health of people. (See: RCW 43.70.520 and RCW 43.70.580) *Standards for Public Health in Washington State* was developed in a collaborative process involving more than 100 public health professionals who work at state and local health departments. They shared their scientific knowledge and practical experience to define standards for the governmental public health system. According to the Department of Health, "*Standards for Public Health in Washington State* provides a common, consistent and accountable approach to assuring that basic health protection is in place." (<http://www.doh.wa.gov/standards/default.htm>)

"The standards cover five key aspects of public health, selected because they represent basic protection that should be in place everywhere:

- Understanding health issues
- Protecting people from disease
- Assuring a safe and healthy environment for people
- Promoting healthy living
- Helping people get the services they need."

“The standards focus on the capacity of our public health agencies to perform certain functions, and not on specific health issues. A public health system that is well organized, meeting a common set of basic standards and adopting best practices, is better prepared to help bring about improvements in health.” (<http://www.doh.wa.gov/standards/default.htm>)

Appendix II – Protocol for CMHD Interviews

Health Director: first interview (1 hr)

I am interested in obtaining three things from this interview:

- Observations about what issues are most important to the health department's long range strategic thinking and how these issues are being dealt with.
- The names and contact information of 3-5 key leaders within the health department staff who can participate in phone interviews and provide more details about the issues and decision processes.
- Guidance on how we can obtain documents related to these issues and categories.

Key Leader interviews (1.5 hour):

- Observations about what issues are particularly important to the health department's long range strategic thinking and how these issues are being dealt with.
- Identify and provide documents related to these issues and categories.

Health Director: final interview (1 hour)

- Review summary of what we have learned.
- Clarify and identify the most important observations.
- Inquire whether or not they would be open to a site visit.

Topical Questions

I. Distinguishing Factors

1. What characteristics of your jurisdiction most influence the mission and services configuration of your LHD?
2. How have the ten essential services influenced the mission and goals of your health department? e.g. explicitly used as a strategic framework, used by programs, used to communicate to stakeholders, use to gauge performance, etc.
3. What characteristics of your LHD are not apparent from your web site and other public information materials? What one source would you recommend to someone wanting to understand your health department?
4. What do you think most distinguishes a public health department serving a major urban metropolitan area from smaller LHDs in terms of mission, service configuration?

II. Health Environment

1. Metro area LHDs face a greater variety of challenges from national, state and even international sources. How important are the following challenges to your LHD: I'd like you to:
 - a. rate them on a scale of 1 to 5 (1= not very important to 5=very important)
 - b. explain why they are important; what is the local impact?
 - c. describe how your health department has responded to these challenges
 - d. describe how your LHD made that decision: e.g. strategic planning, legislative mandate, funding opportunity, etc

List of challenges:

- a) emerging, re-emerging and "globalized" infectious diseases
- b) increasing chronic disease
- c) new mandates such as HIPPA and emergency preparedness
- d) increasing numbers of un- or under-insured people
- e) decreasing and different types of funding for public health services

- f) increasing health inequities,
 - g) diversity and complexity within the populations you serve.
 - h) impact of national and international ports of entry
2. What methods have you used to assess and report on the health status of the community and the services deployed to meet the needs?

III. Policy Environment

- a. For most large LHDs, a variety of factors play a role in determining strategic direction and specific LHD functions: How important are each of these factors below on a scale from 1 to 5 (1= not very important to 5=very important) to your LHD? Why?
 - 1. Community needs as determined by overall demographic characteristics and health status conditions, e.g. aging population
 - 2. Prevailing beliefs about the appropriate function of a LHD especially in relationship to the larger health care system
 - 3. Local tradition and history
 - 4. Legislative mandates and contracts
 - 5. Incremental decision making that tends to layer-on functions over time
 - 6. Threats and crisis including unique risks
 - 7. Opportunities such as funding opportunities (e.g. federal grant programs such as Model Cities and Ryan White)
 - 8. Politics and stakeholder advocacy including elected official and community expectations
 - 9. Current LHD leadership (which can set overall direction, create emphasis and drive change)
 - 10. Division of responsibility between the state and local public health agencies
 - 11. Statutory authority

Let's explore a few of these in greater depth:

Government Mandates

1. What local, state, and federal mandates most define your health department programs?
2. Describe the policy challenges in addressing mandates and needs:
 - a. National, state, and local mandates
 - b. Grants and contracts
3. How do you develop programs in response to government mandates?
4. What governance relationship does your health department have with cities, the state, and the federal government?
5. How would you change these relationships if you could?

Strategic Management

1. How are policy decisions made for non-mandated programs and services?
2. What is driving your role, mission and goals?
3. How do you engage elected officials? What role do they play? Frequency of meetings?
4. What approaches are used to determine the array, configuration, and investment level for the functions and services your LHD provides?
5. What tools are used to make policy decisions (i.e. MAPP, formal strategic planning)?

Operations and Accountability

1. What policies and tools are used for:
 - a) Performance measurement. How does your health department track your progress over time? What performance measurement process do you use (e.g. NPHPS, balanced scorecard, etc)?
 - b) Program evaluation
 - c) Financial and budgetary accountability

IV. Funding and general risks to current funding levels

Most metro health departments face complex fiscal environments characterized by issues such as:

- Shortfall in funding amid expanding expectations

- Integrating categorical and general funding
- Accountability/performance management
- Efficiency and cost-effectiveness
- Changing Medicaid financial policies]

1. How would you characterize your current fiscal challenges?
 - a. trends in funding sources e.g. ratios between federal, state, local
 - b. core discretionary vs. categorical *revenues*
 - c. overall agency fiscal condition and trends
 - d. looming risks for revenue sources

Funding Stream	Risk of Major Decrease	Risk of Minor Decrease	Stable	Chance-Minor Increase	Chance-Major Increase
Local General Funds					
Local licenses and Permits					
Local user fees, insurance and other					
State general fund support					
State categorical fund grants					
Federal grants through state					
Federal direct grants					
Federal/State: Medicaid					
Federal: Medicaid Match					
Other					

2. What are your top funding concerns and why?
3. How have you tried to address those concerns?
4. What opportunities for improved funding streams are you exploring?

Appendix III – Population Characteristics

% Change population, 1990 – 2000

MMHD	1990 total (1990 census)	2000 tot (2000 census)	%Δ 1990 – 2000
PHSKC (King Co)	1,507,319	1,737,034	15.2%
Alameda Co	1,279,182	1,443,741	12.9%
Columbus City, OH	632,910	711,470	12.4%
Davidson Co.	510,784	569,891	11.6%
Miami-Dade Co.	1,937,094	2,253,362	16.3%
Nassau Co.	1,287,348	1,334,544	3.7%

US Census Bureau, Census 1990, Census 2000

% Change population by race, 1990 – 2000

MMHD	White alone	Black or African American alone ¹	American Indian & Alaskan Native alone	Asian & Pacific Islander ²	Other races ³
PHSKC (King Co)	2.9%	23.1%	-8.7%	65.6%	700.7%
Alameda Co	-8.2%	-6.3%	2.8%	58.1%	242.6%
Columbus City, OH	2.6%	21.9%	42.3%	65.8%	1013.9%
Davidson Co	0.01%	23.8%	44.5%	93.2%	1639.7%
Miami-Dade Co.	11.1%	14.9%	42.4%	23.7%	195.1%
Nassau Co.	-5.4%	21.3%	28.6%	61.7%	374.3%

US Census Bureau, Census 1990, Census 2000

¹ 1990 - Black; 2000 - Black or African American alone

² 1990 - Asian and Pacific Islander; 2000 - combined "Asian alone" & "Native Hawaiian and Other Pacific Islander alone"

³ 1990 - Other races; 2000 - combined "Some other race alone" & "Two or more races"

Socioeconomic Status

MMHD	Median household income in 1999 (dollars) ¹	Unemployment rate (annual averages) ²		Poverty (% pop below poverty) ³
		2000	2004	
PHSKC (King Co)	53,157	4.0	5.1	10.4
Alameda Co	55,946	3.6	6.0	11.4
Columbus City, OH	37,897	3.2	5.4	12.8 (county)
Davidson Co.	39,797	3.2	4.4	16.3
Miami-Dade Co.	35,966	5.1	5.6	17.0
Nassau Co.	72,030	3.3	4.5	5.2

¹ US Census Bureau, Census 2000

² US Dept of Labor, Bureau of Labor Statistics; 2000/2004 Annual Averages by county; Columbus rate is for Columbus, OH Metropolitan Statistical Area

³ US Census Bureau, 2004 American Community Survey

Appendix IV – Health Indicators

MMHD	Overall mortality			Heart disease mortality			Cancer mortality			Motor vehicle mortality			Homicide			Infant mortality		
	Rate/ %	Rank ¹	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ	Rate/ %	Rank	% Δ
Seattle (King Co)	840.1	38	-7.9	211.6	41	-18.9	204.5	33	-4.7	8.7	38	-25.6	5.3	39	-42.3	4.6	45	-43.2
Oakland (Alameda Co)	902.7	34	-15.8	249	34	-24.1	207.1	32	-14.8	8.8	37	-39.3	19.1	12	-43.4	5.9	35	-52
Columbus City, OH	1006.1	19	-5.3	267.	31	-21.2	235.5	17	-5.6	8.4	40	-10.6	6.4	36	-38.4	9.9	15	-16.8
Miami (Dade Co)	1257.7	4	5.3	391.2	4	12.6	263.1	5	8.7	30.4	1	-16.5	22.5	7	-39.2	5.4	39	-14.3
Nashville-Davidson (Davidson Co)	942.9	28	-11.4	267.1	30	-26.0	212.8	28	-11.5	21.9	3	.9	14	16	8.7	10.2	13	8.5
New York (Nassau Co)	794.7	43	-24.2	323	10	-18.8	176.9	45	-17.2	5	47	-53.3	8.4	30	-69.4	6.4	30	-44.3

Overall mortality: age adjusted death rate from all causes (e.g. number of deaths per 100,000 population)

Heart disease mortality, Cancer mortality, Motor vehicle mortality, and Homicide is the age adjusted death rate for that cause of death

Infant mortality rate is the number of infant deaths per 1000 live births.

Big Cities Health Inventory 2003

¹ Rank within US 47 largest cities (population ≥ 350,000); a rank of 1 corresponds to the highest rate or percent

Appendix V - PHSKC SERVICE ARRAY
SERVICES MATRIX – PAGE 1 OF 4

Key: KC = King County ALA = Alameda County CC = City of Columbus MD = Miami-Dade NA = Nassau County ND = Nashville-Davidson

	Performed by LPHA directly						Contracted by LPHA						Done by state government agency						Done by another local government agency						Done by someone else						Not available in jurisdiction						
	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	
IMMUNIZATIONS																																					
Adult	X	X	X			X		X	X		X										X			X	X		X		X	X							
Childhood	X	X	X			X		X	X		X										X			X	X		X		X	X							
SCREENING FOR DISEASES/ CONDITIONS																																					
HIV/AIDS	X	X	X		X	X	X	X	X								X							X	X		X		X								
Other STDs	X	X	X		X	X	X		X					X									X	X		X		X		X							
Tuberculosis	X	X	X		X	X	X	X	X		X	X												X	X		X		X								
Cancer	X	X				X	X	X	X		X			X												X	X		X								
Cardiovascular Dx	X	X					X	X	X		X									X					X	X		X		X							
Diabetes	X	X				X	X	X	X		X									X					X	X		X		X							
High blood pressure	X	X	X			X	X	X	X		X									X					X	X		X		X							
Blood lead	X	X	X			X			X		X	X						X						X	X		X		X								
TREATMENT FOR COMMUNICABLE DISEASE																																					
HIV/AIDS	X						X	X			X									X			X		X	X			X								
Other STDs	X		X			X	X	X			X									X			X		X	X			X								
Tuberculosis		X	X			X					X			X						X			X		X	X			X								
MATERNAL AND CHILD HEALTH																																					
Family planning	X		X			X	X		X				X							X				X	X	X		X		X							
Prenatal care	X		X						X		X			X						X				X	X	X		X		X							
Obstetrical	X												X							X				X	X	X		X		X							
WIC	X	X	X		X	X	X		X															X	X												
EPSTD (NA – unknown)	X								X				X										X		X		X										
OTHER HEALTH SERVICES																																					
Comprehensive PC	X						X		X											X					X	X	X		X		X						
Home health care	X						X				X														X	X	X		X		X						
Oral health	X	X	x			X	X		X		X									X					X	X	X		X		X						
Behavioral/ mental health services						X							X						X	X			X	X	X		X		X								
Substance abuse services	X					X													X	X			X	X	X		X		X								

SERVICES MATRIX – PAGE 2 OF 4

Performed by LPHA directly							Contracted by LPHA						Done by state government agency						Done by another local government agency						Done by someone else						Not available in jurisdiction						
EPIDEMIOLOGY & SURVEILLANCE	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	
Communicable/infectious disease	X	X	X		X	X									X		X	X			X			X													
Chronic disease	X	X	X			X	X							X	X		X	X			X			X	X	X	X			X							
Injury	X	X	X		X									X			X	X						X	X		X			X							
Behavioral risk factors	X	X	X		X	X			X					X	X		X	X			X						X										
Environmental health	X	X	X		X	X								X	X		X	X	X	X	X		X														
Syndromic			X			X											X	X																			
POPULATION-BASED PRIMARY PREVENTION SERVICES																																					
Injury	X	X	X		X	X												X			X			X			X			X							
Unintended pregnancy	X	X				X														X				X		X	X	X		X							
Obesity	X	X	X		X	X	X								X			X	X	X	X		X	X	X	X	X	X		X							
Violence	X	X				X								X				X	X	X	X		X	X	X	X	X	X		X							
Tobacco	X	X	X		X	X											X	X							X	X	X	X		X							
Substance abuse	X	X	X			X												X	X				X				X	X		X							
Mental illness						X												X	X				X	X			X			X							

LICENSING
ACTIVITIES

Mobile homes
Campgrounds
& RVs

Solid waste
disposal sites

Solid waste
haulers

Septic tank
installation

Hotels/motels

School/
Daycare

Performed by LPHA directly						Contracted by LPHA						Done by state government agency						Done by another local government agency						Done by someone else						Not available in jurisdiction							
K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D		
			X										X																								
			X										X				X																				
X		X											X			X	x			X																	
X													X			X		X		X	X	X															
X		X			X	X							X					X	X																		
X	3 - H				X	X							X	X							X																

SERVICES MATRIX – PAGE 4 OF 4

Performed by LPHA directly							Contracted by LPHA							Done by state government agency							Done by another local government agency							Done by someone else							Not available in jurisdiction						
OTHER ACTIVITIES	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D	K C	A L	C C	M D	N A	N D					
Emergency medical services	X				X		X	X									X				X	X																			
Animal control	X				X	X													X	X	X		X													X					
Occupational safety & health	X			X		X							X	X					X					X				X		X											
Veterinarian PH activities	X			X		X							X				X		X				X				X									X					
Laboratory services	X	X	X		X	X		X				X	X		X		X	X	X		X																				
Outreach & enrollment for medical insurance	X	X	X			X	X						X	X			X	X	X	X				X	X	X		X		X											
School-based clinics	X						X	X			X								X								X	X								X					
School health	X	X	X			X	X														X						X														
Correctional health	X					X						X												X				X													

Appendix VI – Glossary

- **Local public health agency (LPHA)** is a single governmental organization, regardless of size, providing public health services to the residents of a political jurisdiction; also known as a “local health department.”
- **Metropolitan health department (MHD)** is a local public health agency that provides services to a political jurisdiction with a population of 350,000 or more.
- **Major metropolitan health department (MMHD)** is a local public health agency which is one of the 25 largest metropolitan health departments in the U.S.; while the size of the population served by MMHDs is widely variable, most provide services of close to a million or more people.
- **Comparable metropolitan health department (CMHD)** is a term used specifically for this project and describes one of the five MMHDs to which PHSKC was compared. They include the health departments serving Alameda County (CA), City of Columbus (OH), Miami-Dade County (FL), Nashville-Davidson County (TN), and Nassau County (NY).
- **Personal health care:** encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Clinical services** are provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues, including treatment of illness or injury or prevention of health problems.
- **Primary care** constitutes clinical preventive services, first-contact treatment services, and ongoing care for medical conditions commonly encountered by individuals. Primary care is considered “comprehensive” when the primary care health provider assumes responsibility for the overall provision and coordination of medical, behavioral and/or social services addressing a patient's health problems.
- **Population-based public health services** are interventions aimed at promoting health and preventing disease or injury affecting an entire population, including the targeting of risk factors such as environmental factors, tobacco use, poor diet and sedentary lifestyles, and drug/alcohol use.
- **Health Status:** The current state of health for a given group or population, using a variety of indices including illness, injury and death rates, and subjective assessments by members of the population.
- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.

- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the conditions in which the community population can be healthy.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises service categories that must be in place in all communities to assure an adequate local public health system.